

REPORT ON EXAMINATION
AS TO
MARKET CONDUCT AFFAIRS
OF
BLUE CROSS AND BLUE SHIELD
OF
SOUTH CAROLINA
COLUMBIA, SOUTH CAROLINA
AS OF
DECEMBER 31, 2002
SUBMITTED DECEMBER 1, 2003



**BlueCross BlueShield
of South Carolina**

I-20 at Alpine Road
Columbia, S.C. 29219-0001
803-788-3860

Thomas G. Faulds
President and
Chief Operating Officer
Blue Cross and Blue Shield Division

February 24, 2004

Ms. Dianne H. Irving, CIE, CFE
Chief Market Conduct Examiner
Division of Financial Services
300 Arbor Lake Drive, Suite 1200
Columbia, SC 29223

Re: Report on Examination as to Market Conduct Affairs of Blue Cross and Blue Shield of South Carolina

Dear Ms. Irving:

Thank you for the opportunity to respond to the recommendations made in the report cited above. I am personally committed to making sure that BlueCross BlueShield of South Carolina provides the best possible service to all of our constituents. I consider the Department of Insurance, as our primary regulator, to be one of our constituents. By providing good service to your organization, through careful compliance with all laws and regulations, our organization can further ensure our service levels to our other constituents. We were very pleased with the areas where no audit findings were indicated. For those areas where comments were made, we are committed to complying with your recommendations. The following paragraphs address each of your recommendations:

III.A. Complaint Handling, Page 7

Our ultimate goal is to eliminate complaints by providing fair, prompt and correct claim payment, billing and all other administrative functions. We realize that it is unrealistic to expect to fully achieve this goal with a product as complex as health insurance. As a result, we fully support the need to have the right procedures and controls in place to provide and track complaint resolution.

This section of the report lists four items: a recommendation that we implement procedures to ensure the complaints registers and supporting documentation are maintained based upon Department requirements; a reminder to maintain all records per retention guidelines from the Department; a requirement to comply with South Carolina law requiring prompt response to complaints; and, a requirement to ensure that claims are investigated timely and thoroughly.

Thank you for identifying these items. We will fully comply with the recommendations. Changes in procedure were implemented when each of these items was first brought to our attention. We have taken the following actions:

- It is now our practice to include all identified information in our files.

- We implemented controls to ensure that all documentation is maintained as required.
- Follow-up procedures were implemented to ensure timely response to complaints.

III.B. Grievance Procedures, Page 10

Again, our goal is to minimize any grievances by prompt, correct service to our constituents. We do fully acknowledge the need to have grievance procedures in place to respond promptly and correctly to any grievances that do occur and to keep all necessary and recommended data about the tracking and resolution of grievances.

Your audit report includes the following items: some registers of member grievances for the period covered by the audit were not provided; a recommendation that we maintain separate grievance registers for tracking grievances for insured and other types of business; a recommendation that written responses for first level reviews include the name, title and credentials of each reviewer participating in the first level review process and a notice of the covered person's right to contact the Director of Insurance's office, including the telephone number and address of the Director's office; a recommendation that we timely respond to grievances or appeals by making certifications within thirty (30) days of receipt of the request; a requirement that we notify the originator of an appeal of our determination on the appeal within thirty (30) days after receiving all information necessary to complete the appeal; a recommendation that we develop procedures for preexisting conditions that address these issues at the time of field underwriting and at the time of policy issue, provide information to the consumer that addresses preexisting conditions in clear and precise language, train agents to address the importance of preexisting issues, and instigate procedures to review agents' applications written to determine whether a pattern of declined applications and claims denied exists and take appropriate action.

We are grateful that you brought these items to our attention. Clear, timely responses to grievances and appeals are critical to our goal of providing superior service. We are taking the following actions:

- We acknowledge the fact that some grievance logs could not be located. Controls have been implemented to ensure that complete and accurate registers of grievances will be maintained.
- The registers will distinguish the type of grievance and will be separated by fully insured and ASO accounts.
- Written responses will be modified to include the required information notifying the person of their right to contact the Director of Insurance's office with the necessary telephone number and address.
- Our written correspondence pertaining to first level review of grievances will be modified to include the title and credentials of each reviewer. We respectfully suggest that we not include the full names of the reviewers in the correspondence. Historically, we disclosed the reviewers' full names in our written correspondence. This disclosure led to threatening and intimidating phone calls to

the reviewers. We did not want to subject employees to adverse work conditions and discontinued the use of names in the correspondence for that reason.

- We acknowledge the fact that some of the files reviewed took more than thirty (30) days to complete the appeal and to notify the member in writing. We have implemented controls to assure that we meet this 30-day deadline.

Preexisting conditions present special concerns for medically underwritten health insurance policies. We appreciate your recommendations to focus on these issues and are taking these steps:

- All training material will be reviewed and modified to put additional emphasis on preexisting issues. All training of agents and company personnel will include increased emphasis on preexisting issues.
- All sales literature will be reviewed to determine if additional emphasis is needed for consumers.
- Agents' applications written will be monitored to ensure that there are no patterns of declining acceptance or increased claims denied. Any such patterns will lead to specific review of that agent and any appropriate remedial actions will be taken.

IV.A. Utilization Review – Approvals, Page 13

IV.B. Utilization Review – Denials, Page 14

Consumer-friendly utilization review processes help control the cost of health insurance. It is our goal that these processes be effective, timely and fair to all constituents.

Your review of this area listed four items: a finding that some files were incomplete in that we could not provide copies of the approval letters or copies of the final denial letters; a reminder to provide all appeal certifications within thirty (30) days of receipt of the request; in some cases, we did not send a written denial letter to inform the provider and member of our decision after clinical records were not received for further review; and, some copies of the original denial letter were not provided.

We agree with your findings and have taken the following actions:

- A process change was made in the year 2000 so that letters are now auto-generated and sent to the provider and the member.
- Immediately upon your identification of letter retention issues, we implemented staff education to minimize situations that might lead to the suppression of automated letters.
- When it is necessary to suppress an automated letter, procedures were put in place to manually generate an appropriate letter and mail the letter in a timely manner. A daily log was developed to monitor for automated letter suppression and to ensure the manual creation of necessary letters.
- Reviewed audit findings with staff and trained all staff regarding timely completion of appeals and of all letters.

- A monitoring process was put in place to control the timeliness of all affected letters.
- Letters were developed and are being used to notify members and the requestor of the services when there is insufficient information to review the case.
- We implemented system storage improvements so that all letters will be retained and are accessible.

VI. Producer Licensing, Page 14

A. Active Producers, Page 15

B. Terminated Producers, Page 15

As noted in your report, our company asked you to review, as part of your audit, our current agent appointment and contracting process that was affected by new regulations put in place by the Department on January 1, 2003. This request was made so that we could adopt new administrative procedures to meet the new compliance requirements. We are grateful that you audited this important function.

Your audit identified three items in this area: we did not include a copy of the Department Agent Appointment form in our files; one instance was noted where we did not include a copy of the original Agent Agreement contract; and, records were identified as being terminations that were actually transfers.

Thank you for identifying these issues. We have taken the following actions:

- We began putting a copy of the Department Agent Appointment form in our files in the summer of 2002 following a discussion with an employee of the Department.
- We will comply with all record retention requirements.
- Our agent administrative system, TAPS, was modified to clearly distinguish between agents who were cancelled versus those who were transferred.

VIII. Provider Credentialing, Page 16

Networks utilized for health products in South Carolina are required to credential providers in the network and to re-credential those providers at least every three (3) years. The credentialing process verifies the professional status of the provider.

We agree with all of your findings in the audit. Although very few discrepancies were found, we were reminded to implement procedures to ensure that all provider-credentialing files include all necessary information to verify up-to-date credentialing status.

We have implemented the following changes in our credentialing process as a result of your work:

- We implemented re-credentialing using a county-by-county process with requirements that assure that we will re-credential all providers within a three (3)

year period. Using our new methodology of pulling providers from our provider file for re-credentialing based on county, rather than by individual social security number, will alleviate the problem of missing a provider due to an inaccurate social security number.

- We implemented an annual provider mail-out to validate information that we have on file.
- We implemented two processes to assure that we have contracts on file:
 - When we credential a new provider, we verify that the provider's contract has been appropriately imaged.
 - When we re-credential providers, we verify that we have a contract on file. If we do not have a contract on file, we attempt to get a copy of the original contract from the provider. If the provider does not have a copy of the original contract, we get the provider to sign another contract and we image the new contract with the provider credentialing files.

IV. Claims, Page 17

One of our primary responsibilities as a health insurance company is the accurate, fair and timely payment of claims. We appreciate your review of our claim processes and have made improvements as a result of your recommendations.

IX.A. Individual and Small Group - Paid Claims, Page 17

Your audit of this claims area noted that 95% of the sample claims were paid within 10 days, but 5% took more than sixty (60) days, and you recommended that we monitor paid claim transactions that exceed sixty (60) days, from the date of proof of loss to the paid date to ensure timely payment of claims.

We appreciate your review and have taken the following actions:

- We implemented processes to monitor claims timeliness when additional information is required for final determination.
- The process for handling subrogation adjustments has been moved from the Claims area to the Subrogation area, eliminating the transfer of information required for claims adjudication, allowing us to meet the sixty (60) day deadline.

IX.B. Large Group – Paid Claims, Page 18

Your audit of this area did not find any timeliness or other issues with the claims. However, your sample included ASO claims, which were invalid for your audit, as well as insured claims when only insured claims were desired. As a result, your audit report stated that we should ensure compliance with South Carolina law, which provides that we should keep a full and correct record of our business.

Thank you for your input in this area. Our data systems include extensive identification coding that allows us to segment data in a wide variety of ways including distinguishing between insured and ASO claims.

- We will emphasize that proper procedures are followed by our staff to ensure proper use of data identification.

IX.C. Medicare Supplement – Paid Claims, Page 19

Your audit of this area did not find any timeliness or other issues with the claims. However, your sample of claims included records for transactions administered by Advance PCS that did not represent actual paid Medicare Supplement claims. Your audit report stated that we should ensure compliance with South Carolina law, which provides that we should keep a full and correct record of our business.

We concur with your recommendation that we need to maintain full and complete records and have taken the following action:

- We initiated a change in our systems to correctly code these transactions in our data.

IX.D. Individual – Denied Claims, Page 20

Your audit report noted two (2) claims that were actually paid claims, not denied and ten (10) claims that took longer than thirty (30) days to deny from the date that proof of loss was received. Your report stated that we should follow all South Carolina laws and regulations, which provide that claims are settled in a timely manner as required by statutes, rules and regulations.

Thank you for your findings. We agree with your recommendations and have taken the following actions:

- We modified our processes to ensure expeditious claim resolution, particularly where we are requesting additional information.
- We generate new, additional reports to show all outstanding requests.

IX.E. Small Group – Denied Claims, Page 21

Your audit report noted one (1) claim that was actually a paid claim, one (1) claim that was deemed an incomplete record since the section of the Explanation of Benefits representing the denied portion could not be provided and six (6) claims that took longer than thirty (30) days to deny from the date that proof of loss was received. Your report stated that we should follow all South Carolina laws and regulations, which provide that claims are settled in a timely manner as required by statutes, rules and regulations.

Thank you for your findings. We agree with your recommendations and have taken the following actions:

- We modified our processes to ensure expeditious claim resolution, particularly where we are requesting additional information.

- We generate new, additional reports to show all outstanding requests.

IX.F. Large Group – Denied Claims, Page 22

Thank you for your review of this area. Your audit report noted one (1) claim was paid and one (1) claim that took longer than thirty (30) days to deny. You recommend that we establish procedures to ensure proper identification of claims history data and such information is consistent with market conduct examination requirements.

We will emphasize to staff that proper procedures are followed to ensure proper identification of data. In addition, we are taking the following actions:

- We modified our processes to assist with expeditious claim resolution, particularly where we are requesting additional information.
- We generate new, additional reports to show all outstanding requests.

IX.G. Medicare Supplement – Denied Claims, Page 23

Thank you for your review of this area. Your report did not note any timeliness or other problems with this area. However, you noted that ten (10) of the claims reviewed were deemed invalid since they belonged to an affiliated company and stated that we should ensure compliance with all South Carolina laws and other requirements to provide that claim files are adequately documented.

Our records indicate that these ten (10) denied claims were for members who are part of a block of business purchased by the Companion Life Company from Liberty Life Insurance Company, in 1994. BlueCross BlueShield of South Carolina has a written agreement with Companion Life to administer the claims for this block of business. The documentation provided and reviewed properly had the Companion Life logo on the remittances and Explanations of Benefits.

IX.H. Open Claims, Page 23

Your review of these claims found seven (7) claims were incomplete and your audit report stated that we should ensure compliance with South Carolina law, which provides that we should keep a full and correct record of our business.

We agree with your findings. We acknowledge the fact that all claim files were not adequately documented. We have taken the following actions as a result of your work:

- Controls were established to ensure that all future claims are properly documented.
- Procedures were updated to ensure that Explanations of Benefit are issued on duplicate claims filings by providers.

IX.I. Litigated Claims, Page 24

Your report observes that thirty-eight (38) litigated claims files were provided for review, representing all fully insured claims litigated from 1997 through 2001, and thirty-two (32) were settled. You further recommend that we implement procedures to ensure claims are paid timely without insured/provider having to seek legal representation to have such claims paid.

Thank you for your review of this important area. We are pleased that, in today's litigious society, there were only thirty-eight (38) claims in this category. The thirty-two (32) settled claims represent an average of fewer than 6.5 claims per year in this group. We currently process over 8,000,000 fully insured claims per year.

However, we agree that we should take every step possible to further reduce claims in this category. We have established a process that we believe will alleviate much of the risk that an insured/provider has to initiate litigation to get a claim paid. We have the following procedures in place:

- Staff is in place to review and respond to threatened litigation to make sure that an insured/provider does not need to seek legal recourse to have a claim paid.
- If litigation is filed, we have staff who review the claim to make sure that we have not made an error in processing.

I appreciate the opportunity to respond to your recommendations and have the responses included as part of the Report on Examination as to Market Conduct Affairs of Blue Cross Blue Shield of South Carolina. I believe that the process changes that we were able to implement as a result of your recommendations will help us continue to provide superior service to our constituents.

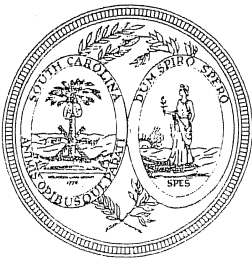
Sincerely,



Thomas G. Faulds
President and Chief Operating Officer

From: "CHARLES HIGGINS" <CHARLES.HIGGINS@bcbssc.com>
To: <dirving@doi.state.sc.us>
Date: 2/19/04 12:23PM

Diane, thanks for the extension of one week to reply to the BCBSSC Market Conduct Review. We are in process of obtaining responses from all involved areas with some minor delay due to year end workload, but will have a response to you by 2-27-04. Charlie Higgins



South Carolina Department of Insurance

Division of Financial Services
Office of Market Conduct Examinations
300 Arbor Lake Drive, Suite 1200
Columbia, South Carolina 29223

MARK SANFORD
Governor

ERNST N. CSISZAR
Director of Insurance

Mailing Address:
P.O. Box 100105, Columbia, S.C. 29202-3105
Telephone: (803) 737-6209
January 21, 2004

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Thomas G. Faulds
President and Chief Operating Officer
Blue Cross and Blue Shield of South Carolina
2501 Faraway Drive
Columbia, South Carolina 29219

Dear Mr. Faulds:

Enclosed herewith is a copy of the Report on Examination as to Market Conduct Affairs of Blue Cross and Blue Shield of South Carolina of Columbia, South Carolina, as of December 31, 2002, made pursuant to S. C. Code Ann. § 38-13-10 (A) (as amended).

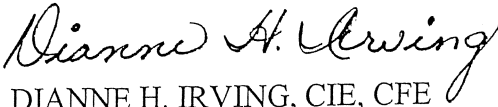
Your attention is directed to the following items within the Report:

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Your written response should be received by this Department within thirty (30) days from the date of this letter. If you have any questions or concerns, I can be reached at (803) 737-6209, or facsimile transmission number (803) 737-6232.

Yours truly,


DIANNE H. IRVING, CIE, CFE
Chief Market Conduct Examiner

cc: Gwendolyn L. Fuller, Deputy Director and General Counsel

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Columbia, South Carolina
December 1, 2003

Honorable Ernst N. Csiszar
Director of Insurance
Department of Insurance
State of South Carolina
Post Office Box 100105
300 Arbor Lake Drive, Suite 1200
Columbia, South Carolina 29202-3105

Sir:

Under authority delegated by you pursuant to S.C. Code Ann. § 38-13-10 (A) (as amended) and in accordance with your instructions and the practices and procedures of the National Association of Insurance Commissioners (NAIC) and the South Carolina Department of Insurance (Department), an examination has been conducted, as of December 31, 2002, of the market conduct affairs of

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA
COLUMBIA, SOUTH CAROLINA

hereinafter generally referred to as the "Insurer" at its office located at 2501 Faraway Drive, Columbia, South Carolina. The report of such examination is hereby respectfully submitted.

I. SCOPE OF THE EXAMINATION

The planning process for this full scope market conduct examination commenced November 19, 2002, at the Department. The on-site field examination commenced February 10, 2003, and concluded August 14, 2003. Work paper completion and review was conducted at the Department subsequent to completion of the on-site fieldwork. This Report on Examination (Report) covers the period from January 1, 1997, through December 31, 2002. Any records subsequent to this date were reviewed, if deemed necessary. This market conduct examination was conducted in accordance with guidelines of the Department and criteria and standards as set forth in the NAIC Market Conduct Examiners Handbook, Volume II, (NAIC Market Conduct Examiners Handbook).

II. INSURER OPERATIONS/MANAGEMENT

A. History:

The Insurer is a for-profit mutual insurance company and is the largest health insurer and health benefits administrator domiciled in South Carolina. The Insurer was originally known as the South Carolina Hospital Service Plan and changed its name to Blue Cross of South Carolina. The South Carolina Hospital Service Plan was organized in 1946 pursuant to Act No. 417 of the Acts and Joint Resolutions of the General Assembly of 1946 as a nonprofit corporation to operate a hospital service plan. Act No. 417 provided that any entity chartered under its provisions was exempt from all taxes on its funds, operations and properties.

The Insurer is the successor by merger of Blue Shield of South Carolina. Blue Shield of South Carolina was originally known as the South Carolina Medical Care Plan. The South Carolina Medical Care Plan was organized in 1949 pursuant to Act No. 713 of the Acts and Joint Resolutions of the General Assembly of 1948 as a nonprofit medical service corporation. Act No. 713 provided that a corporation organized under its provisions was exempt from all taxes on its funds, operations, and properties.

In 1968, a major change occurred in the statutory framework surrounding the companies.

Act No. 1098 of the Acts and Joint Resolutions of the General Assembly of 1968 repealed in their entirety Chapters 13 and 14 of Title 37 (where the earlier referenced Acts were codified) and converted the companies to business corporations operating as mutual insurance companies, subject to taxation. Effective January 1, 1969, the companies became domestic mutual insurance companies authorized to write accident and health insurance. On January 1, 1973, Blue Shield of South Carolina merged into Blue Cross of South Carolina at which time the Insurer became known as Blue Cross and Blue Shield of South Carolina.

B. Officers and Directors:

The Officers and Directors, as of December 31, 2002, were as follows:

Malcolm E. Sellers	President and Director
Robert A. Leichtle	Treasurer
Vivian B. Gray	Secretary
Thomas G. Faulds	Vice President
William R. Horton	Vice President
Michael J. Skarupa	Vice President
Timothy S. Blackwell	Vice President
Wayne T. Roberts	Vice President
Edmund S. Pendleton, Jr.	Vice President
John M. Little, MD	Vice President
Dale L. Rish	Vice President
Dwight M. Wicker	Vice President
Richard P. Butler	Vice President
James A. Deyling	Vice President
Donald B. Nystrom	Vice President
James M. Hart	Vice President
Charles L. Higgins	Vice President
William M. Griggs	Vice President
Robert W. Johnson	Vice President
Steve V. Fange	Vice President
Bruce W. Hughes	Vice President
Barbara A. Kelly	Vice President
Bruce E. Honeycutt	Vice President
George L. Johnson	Vice President
Ashby M. Jordan, MD	Vice President
William R. Shrader	Vice President
William J. Meyer	Vice President
Allen K. Gardner	Vice President
Jean S. Smith	Vice President
Ronald L. Rushton	Vice President
Margaret S. Archibald	Vice President

David J. Huntington	Vice President
Joseph D. Wright	Vice President
Carolyn F. Ferguson	Vice President
Danny R. Grunsky	Vice President
Judith M. Davis	Vice President
Stephen K. Wiggins	Vice President
William H. Ferguson	Vice President
Thomas J. Littlefield	Vice President
Kay L. Andrews	Vice President
Roslyn C. Catoe	Vice President
Brittie S. Percy	Vice President
Mark A. Macdougall	Vice President
Joseph F. Sullivan	Director
William L. Amick	Director
Edwin E. Maddrey II	Director
Merl F. Code	Director
Helen E. Clawson	Director
John M. Trask	Director
Harry R. Easterling	Director

C. Plan of Operation:

The Insurer provides accident and health insurance benefits through individual and group plans and also issues supplemental Medicare insurance coverage. The Insurer acts as a third-party administrator for Medicare, State of South Carolina employees, and other groups on a no-risk retention basis for an administrative fee. The Insurer is the fiscal intermediary and carrier for the Department of Defense administering and providing health insurance coverage under various TRICARE (formerly CHAMPUS) contracts. On a national basis, the Insurer has become the largest supplier of administrative services for both TRICARE and Medicare federal government health insurance programs. In addition, through the Blue Cross Blue Shield Association (BCBSA) and other "Blues", the Insurer underwrites health benefits for employees of the federal government under the Federal Employees Plan (FEP). The Insurer also pays claims, directly submitted, under contracts issued by other "Blues" for participants in the South Carolina area, even if the Insurer is not a participant in the group. The Insurer may also act as the control plan under other national groups when the Insurer is the administrator of the plan and reimburses other "Blues" for claims paid in their

area. The Insurer uses the inter-plan teleprocessing technology supplied by BCBSA to process the interstate and FEP claims electronically.

In addition to the core health insurance coverage, health benefits administration and government program lines of business; the Insurer and affiliates also provide life insurance, property and casualty insurance, information technology and investment management services.

D. Affiliated Agreements:

The Insurer provides offices, and other facilities and services under Administrative Services Agreements with each of its primary affiliated insurance subsidiaries. As of December 31, 2002, the Insurer had executed the required Business Associate Agreement between Companion HealthCare Corporation and Companion Life Insurance Company, for privacy protection issues, as required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

E. Disaster Recovery:

The Insurer's Disaster Recovery Plan (Plan) is a two-phase plan: Phase 1 of the Plan encompasses the six-week period immediately following a disaster. The Plan addresses the vital business functions of the Insurer by providing for alternative processing methods to handle those applications that are necessary for corporate survival. Phase 2 of the Plan, explains what happens once the hotsite is fully equipped and operational, as well as the contractual agreement of the systems vendors. The review also included the disaster recovery data backup and off-site storage procedures. The Plan is well documented and appears to be adequate and up-to-date.

F. Privacy Compliance:

A review was made of the "Private Business Policy and Procedures Manual" used by the Insurer. The review also included the Confidentiality and Disclosure of Claims and Coverage Information documentation. Review of correspondence provided to each member does include the required Privacy Notice disclosure. It appears the Insurer is in compliance with state privacy documentation and disclosure requirements.

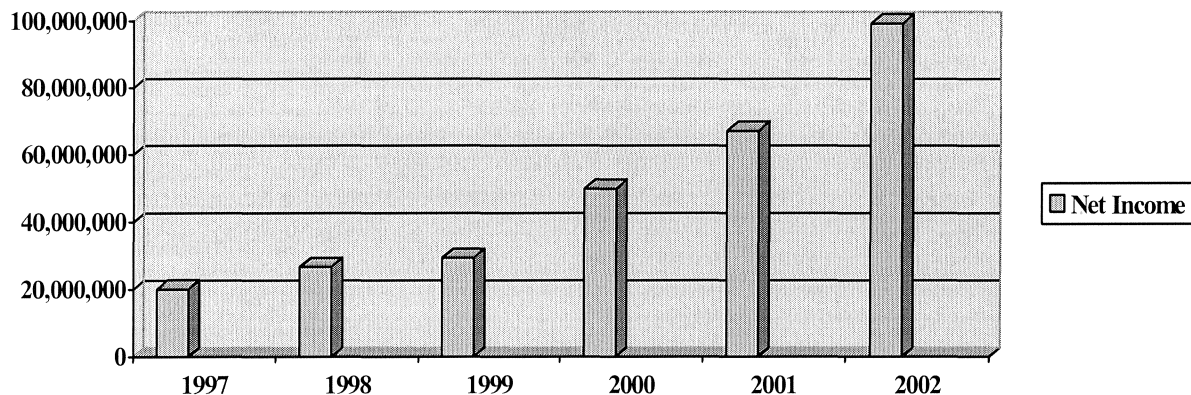
G. Six -Year Historical Data:

The following shows the operations of the Insurer, as reported in filed annual statements, for the past six (6) years:

<u>Year</u>	<u>Net Admitted Assets</u>	<u>Total Capital and Surplus</u>	<u>Gross Premiums Written</u>	<u>Net Premiums Written</u>	<u>Net Income (Loss)</u>
1997	\$440,711,620	\$230,545,915	\$536,410,410	\$534,582,629	\$20,125,931
1998	\$481,282,344	\$266,516,652	\$479,533,808	\$477,956,642	\$26,741,576
1999	\$534,294,609	\$293,771,426	\$580,200,744	\$577,443,520	\$29,456,866
2000	\$605,841,155	\$325,083,591	\$663,397,738	\$660,095,772	\$49,946,806
2001 *	\$772,734,459	\$403,127,042	\$767,497,547	\$763,512,926	\$67,087,119
2002	\$923,078,538	\$500,118,323	\$937,699,282	\$935,518,369	\$99,241,065

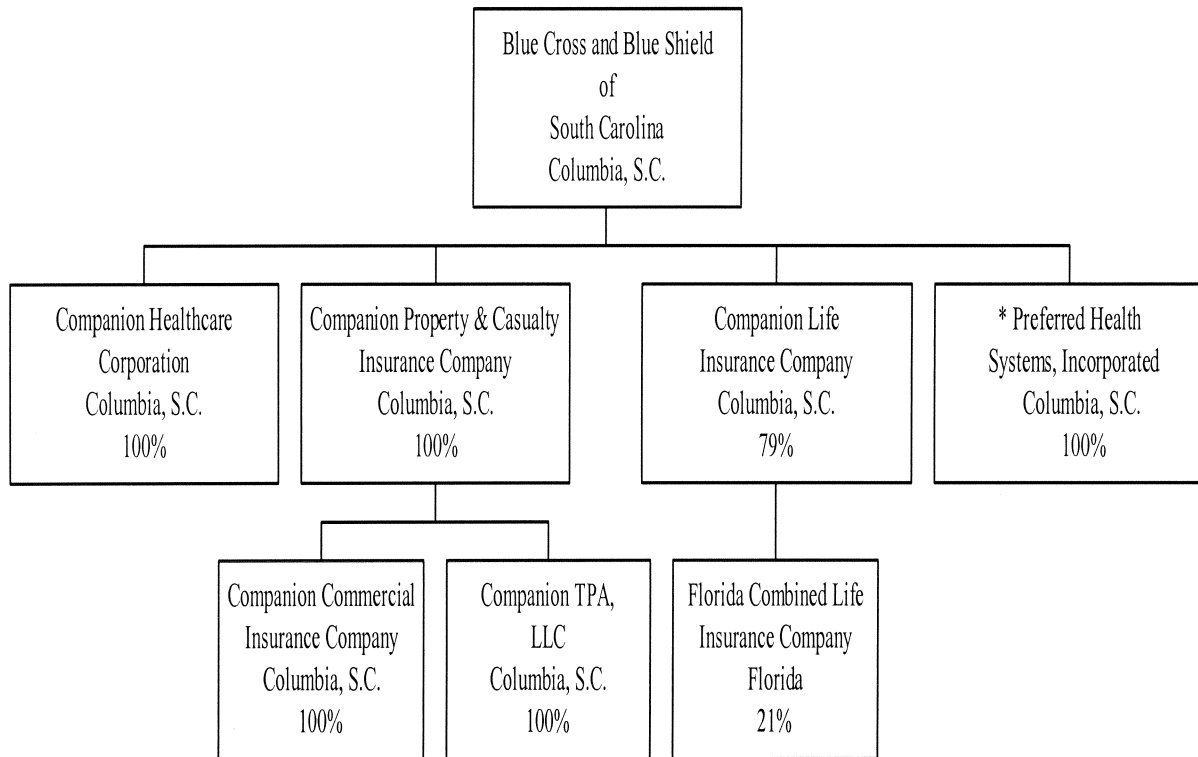
* Denotes results as determined by the Department's financial examination as of December 31, 2001.

H. Analysis of Net Income:



I. Organizational Chart:

The following organizational chart, as of December 31, 2002, shows the interrelationship between the Insurer and significant insurance affiliates:



* Preferred Health Systems, Incorporated voluntarily withdrew from conducting business in South Carolina effective December 31, 2002.

III. COMPLAINT HANDLING/GRIEVANCE PROCEDURES

A. Complaint Handling:

NAIC and Department definitions of a complaint is a written communication primarily expressing dissatisfaction with procedures. A review was made of the Insurer's procedures for processing consumer or other related complaints to:

1. determine if any pattern or specific types of complaints were evident;
2. determine the final disposition of the complaint, and, if actions taken by the Insurer were in conformance with statutes, rules and regulations; and
3. determine the promptness of the Insurer's responses to complaints and inquiries.

Direct consumer complaints received by the Insurer were included as part of the Insurer's Grievances log and included as part of the Grievance procedures review.

The Department received approximately fifteen hundred (1500) consumer complaints during the six (6) year examination period, including one thousand three hundred and twenty six (1326) complaints from fully insured customers. The balance represented complaints received from employees of self-funded insurance groups and members of the State of South Carolina Employees Health Insurance Plan. The Insurer acts as Claims Administrator for the State of South Carolina Employees Health Insurance Plan. The sample chosen for examination review was limited only to the consumer complaints representing fully insured plans sold by the Insurer.

A sample of fifty (50) Department consumer complaints' files for the period under examination was reviewed utilizing recommended Standards from the NAIC Market Conduct Examiners Handbook and selected by use of the Market Conduct Statistical Utilities software program. The following were noted:

1. The Insurer did not always record the total information needed to maintain the consumer complaints' register in accordance with Department requirements. The complete copies of the 1997, 1998 and 1999 consumer complaints' registers could not be provided by the Insurer. The NAIC guidelines adopted by the Department for maintaining a consumer complaints' register are as follows:
 - a. Date complaint received (based on date stamp);
 - b. Department complaint file reference number;
 - c. Name of individual filing the complaint with the Department;
 - d. Name of the insured/member;
 - e. Policy number or member ID number;
 - f. Purpose of complaint;
 - g. Type of insurance product or plan;
 - h. Name of responsible person to investigate complaint;
 - i. Date complaint response letter sent to the Department; and
 - j. Explanation of resolution to the complaint.

It is recommended the Insurer implement procedures to ensure the complaints' registers and supporting documentation are maintained based upon Department retention requirements.

2. One (1) or two percent (2%) of the complaint files could not be provided.

While not indicating that a pattern of errors exists, the Insurer is reminded to maintain all records as required by retention guidelines of the Department.

3. Eleven (11) or twenty two percent (22%) of the complaints' files were not handled on a timely basis per the Department's instructions to provide a complete response within fifteen (15) days of receipt of the complaint.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann § 38-13-160 (as amended) which provides,

"The director or his designee may require any authorized insurer or its officers to answer any inquiry in relation to its transaction, conditions, or any connected matter necessary to the administration of the insurance laws of the State. Every corporation or person must reply in writing to the inquiry promptly and truthfully, and the reply must be verified, if required by the director or his designee, by the individual or by the officer or officers of a corporation as he designates. These replies are strictly confidential."
 - b. NAIC Market Conduct Examiners Handbook – Complaint Handling - Standard 4, "The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations."
4. Eighteen (18) complaints or thirty-six percent (36%) were claims related and were overturned and either paid or corrective action was taken. The Insurer should ensure that claims are investigated timely and thoroughly to comply with:
 - a. S.C. Code Ann § 38-59-20 (as amended) which provides,

"Any of the following acts by an insurer doing accident and health insurance, property insurance, casualty insurance, surety insurance, marine insurance, or title insurance business, if committed without just cause and performed with such frequency as to indicate a general business practice, constitutes improper claims practices.

(8) Any other practice which constitutes an unreasonable delay in paying or an unreasonable failure to pay or settle in full claims, including third-party liability claims, arising under coverages provided by its policies."

The following provides a summary of the Department complaints reviewed:

<u>Description</u>	<u>Number</u>	<u>% of Total</u>
Claims related	39	80%
Policyholder Service	8	16%
Provider Relations	<u>2</u>	<u>4%</u>
Total	<u>49</u>	<u>100%</u>

B. Grievance Procedures:

A review was made of the Insurer's procedures for processing consumer grievances to:

- a. determine if any pattern or specific type of member grievance was evident;
- b. determine the final disposition of the grievances, and if actions taken by the Insurer were in conformance with statutes, rules and regulations; and
- c. determine the promptness of the Insurer's responses to member grievances and inquiries.

The review of fifty (50) grievance files for the period under examination were reviewed utilizing recommended Standards from the NAIC Market Conduct Examiners Handbook and selected by use of the Market Conduct Statistical Utilities software. The following were noted:

1. The Insurer could not provide full and complete registers of all member grievances received during the examination period.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann. § 38-13-20 (B) (as amended) which provides,

“Every person or insurer and his or its officers, directors, and agents from whom information is sought shall provide to the examiners appointed under subsection (A) timely, convenient, and free access at all reasonable hours at his or its offices all books, records, accounts, paper, documents, and all computer or other recordings relating to the property, assets, business, and affairs of the person or insurer being examined. If the director or his designee considers it necessary to the conduct of the examination, he may require that the person or insurer or his or its agents or affiliated or subsidiary corporations or partnerships furnish the original books and records...” and

- b. Grievance registers were not properly prepared and registers that were provided, included fully insured, self-funded accounts and State of South Carolina employees grievances logged together, without any special identification process to separate all administrative plans from the fully insured member grievances.

It is recommended the Insurer maintain separate grievance registers for tracking grievances by fully insured and ASO accounts in such a manner that clearly specifies the type of grievance.

2. It was noted that during the examination period, the Insurer did not, in its written response, include the following information, for all written decisions issued pursuant to a first level review:
 - The name, title, and qualifying credentials of each reviewer participating in the first level review process; and
 - Notice of the covered person's right to contact the Director of Insurance's office, including the telephone number and address of the Director's office;

It is recommended the Insurer provide this information in accordance with NAIC Market Conduct Examiners Handbook, Standard 4, under "Grievance Procedures" which states, "The health carrier conducts first level reviews of grievances in compliance with statutes, rules, and regulations".

3. Sixteen (16) grievances or thirty-two percent (32%) took longer than five (5) business days to send the response letter to the provider or member after determination of decision.

It is recommended the Insurer timely respond to grievances or appeals to comply with S.C. Regs. Ann. 69-47 § IV. A. 1., which requires certifications to be made within thirty (30) days of receipt of the request.

4. Thirty-one (31) or sixty-two percent (62%) of the files reviewed, indicated it took more than thirty (30) days after receiving information necessary to complete the appeal, to notify in writing the person or entity who initiated the request.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Reg. 69-47 § V. 1. b. Standard Appeal, which provides,

“Private review agents must notify in writing the person or entity who initiated the request, or the patient, enrollee, insured, or other party designated of its determination on an appeal, as soon as practical, but in no case later than thirty days after receiving all information necessary to complete the appeal...”

5. Twenty (20) grievances or forty percent (40%) of the grievances reviewed, were based on preexisting conditions that were discovered after the health plans were issued (determined on claims based underwriting).

It is recommended the Insurer develop procedures to:

1. address these issues at time of field underwriting and at time of policy issue;
2. provide information to the consumer, that addresses preexisting conditions in very clear and precise language;
3. train agents of the importance of preexisting issues; and
4. instigate procedures to review agents' applications written to determine whether a pattern of declined applications and claims denied exists and take appropriate action.

The following is a summary of the cause for the appeals for the files sampled:

<u>Description</u>	<u>Number</u>	<u>Percent of Total</u>
Pre-existing Conditions	20	40%
Medically Necessary	18	36%
Benefit not Covered	8	16%
Claims Administration	4	8%
Total	50	100%

IV. UTILIZATION REVIEW/CARE MANAGEMENT

S.C. Regs. 69-47 § II J. defines “Utilization Review” as “A system for reviewing the necessary, appropriate, and efficient allocation of health care resources and services given or proposed to be given to a patient or group of patients.” S.C. Regs. § 69-47 II. I. defines “Utilization Criteria” as “The written policies, rules, medical protocols, or guides used by the private review agent to review, grant or deny certification.” This examination included a review of the minutes of the Quality Assurance, Utilization Review and Grievance Committees along with a detailed review

of the utilization process. All committees met on a regular schedule and all meetings appeared to be adequately documented. Such meetings included the discussions of treatment protocols, recommendations made, recommendations implemented and other actions taken by the committees.

A. Utilization Review – Approvals:

A sample of one hundred (100) files was selected using Automated Computer Language (ACL) software. These files were reviewed to determine medical necessity, efficiency, procedures, and justifiable reasons for utilization review. The following were noted:

1. Seventeen (17) files or seventeen percent (17%) were deemed to be incomplete records in that the Insurer could not provide copies of the approval letters or copies of the final denial letters.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann. § 38-13-120 (as amended), which provides,

“All companies doing any kind of insurance business in this State shall make and keep a full and correct record of the business done by them...;”
 - b. NAIC Market Conduct Examiners Handbook - Utilization Review – Standard 6 - The health carrier provides written notice in compliance with statutes, rules, and regulations for an adverse determination; and
 - c. S.C. Code Ann. § 38-13-20 (B) (as amended) which provides,

“ Every person or insurer and his or its officers, directors, and agents from whom information is sought shall provide to the examiners appointed under subsection (A) timely, convenient, and free access at all reasonable hours at his or its offices to all books, records, accounts, papers, documents, and all computer or other recordings relating to the property, assets, business, and affairs of the person or insurer being examined.....”
2. Two (2) files or two percent (2%) indicated that a certification appeal was not rendered within thirty (30) days of receipt of the request.

While not indicating that a pattern of errors exists, the Insurer is reminded to provide all certifications within thirty (30) days to ensure compliance with S.C. Regs. 69-47 § V. 1. b. requiring notification be provided to the person or entity requesting the review within thirty (30) days.

B. Utilization Review – Denials:

A sample of fifty (50) files was selected using ACL software. These files were reviewed to determine medical necessity, efficiency, procedures, and justifiable reasons for utilization denial.

The following were noted:

1. A total of ten (10) files, or twenty percent (20%) were deemed to be invalid or incomplete for the following reasons:
 - a. Seven (7) files were closed after clinical records were not received for further review. The Insurer did not send a written denial letter to inform the provider and member of their decision.
2. Three (3) files were incomplete, as the Insurer could not provide copies of the original denial letters.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann. § 38-13-120 (as amended), which provides,
“All companies doing any kind of insurance business in this State shall make and keep a full and correct record of the business done by them....;” and
- b. NAIC Market Conduct Handbook – Utilization Review – Standard 6 – “The health carrier provides written notice in compliance with statutes, rules, and regulations for an adverse determination.”

V. MARKETING AND SALES

A review was made of marketing and sales materials presented by the Insurer for the years under review. The policy benefits, limitations and exclusions, terms and conditions all appear to be fairly disclosed. The sales materials contained no misleading or incomplete statements. A sample review of communications sent to the Insurer’s sales force revealed no exceptions. The Insurer does maintain an Internet Web page or domain in its name, allowing consumers access to provider directories, benefit information, claims status and links to value-added services such as general health and wellness information and online ordering of prescription drugs. No exceptions were noted.

VI. PRODUCER LICENSING

The Insurer’s listings of South Carolina licensed, appointed, and terminated agents for the

period under review were reconciled with the Department's listings of active and inactive agents.

As of December 31, 2002, the Department had licensed approximately twenty six hundred (2,600) active agents to represent the Insurer.

At the request of the Insurer, a review was made of the current agent appointment and contracting process that was affected by new regulations put in place by the Department on January 1, 2003. The process allowed the Insurer to adopt new administrative procedures to meet the new compliance requirements.

A. Active Producers:

Fifty (50) appointed agents' files were reviewed for timely notification of the appointment process. The following was noted:

1. Forty-two (42) files, or eighty four percent (84%) did not include a copy of the Department Agent Appointment form and one (1) file or two percent (2%) did not include a copy of the original Agent Agreement contract.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann. § 38-13-120 (as amended), which provides,

"All companies doing any kind of insurance business in this State shall make and keep a full and correct record of the business done by them....;" and
- b. NAIC Market Conduct Examiners Handbook – Producer Licensing –
Standard 2 – Producer Licensing, appointment forms should be properly completed.

B. Terminated Producers:

Fifty (50) terminated agents' files were reviewed for reasons for termination and timely notification to the Department and to the terminated agent. The following were noted:

1. Twenty-nine (29) files or fifty eight percent (58%) were deemed to be invalid records due to not being actual terminations, but instead were transactions for agent transfers.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann. § 38-13-120 (as amended), which provides,

"All companies doing any kind of insurance business in this State shall make

and keep a full and correct record of the business done by them...,” and

- b. NAIC Market Conduct Examiners Handbook – Producer Licensing – Standard 1 – Producer Licensing - Licensing records should be maintained to clearly show dates of appointment and termination for each agent.

VII. PROVIDER CREDENTIALING

A review was made of the Insurer’s provider credentialing procedures. The review included verifying that the health carrier maintains a program for credentialing and re-credentialing, that the health carrier verifies the credentials of a health care professional before entering into a contract with that health care professional, that the health carrier obtains primary verification of the information required by state provisions, that the health carrier obtains, at least every three (3) years, primary verification of the information required by state provisions and that the health carrier provides a health care professional the opportunity to review and correct information submitted in support of the health care professional’s credentialing verification.

A sample of one hundred (100) provider files was chosen using ACL software. The following were noted:

1. Two (2) or two percent (2%) of the files were noted for not being properly re-credentialled due to query error. The Insurer took immediate action for recredentialing the providers;
2. One (1) or one percent (1%) of the files was deemed to be invalid as the provider had been inactive since 6/1/96;
3. One (1) or one percent (1%) of the files represented a clerical error where the provider’s social security number was entered into the computer system incorrectly, thereby causing the provider not to be timely re-credentialled; and
4. One (1) or one percent (1%) of the files was noted for not including the contract.

While not indicating that a pattern of errors exists, the Insurer is reminded to implement procedures to ensure that all provider-credentialing files include all necessary information to verify up-to-date credentialing status.

VIII. UNDERWRITING AND RATING

Underwriting practices and rating procedures were reviewed to determine compliance with the appropriate statutes, regulations, rules and policy provisions. The following were noted from the files reviewed:

A. Individual and Group - New Business – Issued:

A sample of one hundred (100) files was selected using ACL software. These files were reviewed to ensure that the Insurer was properly issuing coverage to eligible members, using agents who had been properly appointed to produce business for the Insurer and following all statutes, rules and regulations regarding underwriting and rating. No exceptions were noted in the files reviewed.

B. Medicare Supplement - New Business – Issued:

A sample of one hundred (100) files was selected using ACL software. These files were reviewed to ensure the Insurer was properly issuing coverage to eligible members, using agents who had been properly appointed to produce business for the Insurer and following all statutes, rules and regulations regarding underwriting and rating. No exceptions were noted in the files reviewed.

C. Individual and Group Business – Terminations:

A sample of one hundred (100) terminated files was selected using ACL software. These files were reviewed for compliance with appropriate statutes, regulations, rules and company procedures. No exceptions were noted in the files reviewed.

IX. CLAIMS

The Insurer's claims' practices were reviewed to determine compliance with South Carolina laws, rules and regulations and policy provisions. The review encompassed paid claims, denied claims, open claims and litigated claims.

A. Individual and Small Group - Paid Claims:

A sample of one hundred (100) individual and small group paid claims was selected for review using ACL software. The following were noted in the files reviewed:

1. Five (5) claims, or five percent (5%) took longer than sixty (60) days to process for payment;
2. One (1) file or one percent (1%) represented a Medicare claim that was coded incorrectly;
3. Two (2) claims involved subrogation adjustments that took longer than sixty (60) days to resolve; and
4. Two (2) claims were out of state claims processed for members for which the Insurer did not have complete control of the claim transactions.

It is recommended the Insurer monitor paid claim transactions that exceed sixty (60) days, from the date of proof of loss to the paid date, to ensure timely payment of claims for compliance with:

- a. S.C. Code Ann. § 38-71-735 (j) which provides,

“A provision that all benefits payable under the policy other than benefits for loss of time will be paid not more than sixty days after receipt of proof of loss.....”

The time study for individual and small group paid claims from proof of loss completion date to date paid provides the following data:

<u>Number of Days</u>	<u>Number of Claims</u>	<u>Percent of Total</u>
0 – 10	95	95%
11 – 20	0	0%
21 – 30	0	0%
31 – 60	0	0%
> 60	<u>5</u>	<u>5%</u>
Total	<u>100</u>	<u>100%</u>

B. Large Group - Paid Claims:

A sample of fifty (50) large group claims was selected for review using ACL software.

1. Twenty-six (26) files, or fifty two percent (52%), were deemed invalid records, as they represented ASO account claims.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann. § 38-13-120 (as amended), which provides,

“All companies doing any kind of insurance business in this State shall make

and keep a full and correct record of the business done by them....” and

- b. NAIC Market Conduct Examiners Handbook – Claims - Standard 5 – Claim files are adequately documented

The time study for large group paid claims from proof of loss completion date to date paid provides the following data:

<u>Number of Days</u>	<u>Number of Claims</u>	<u>Percent of Total</u>
0 – 10	23	96%
11 – 20	1	4%
21 – 30	0	0%
31 – 60	0	0%
> 60	<u>0</u>	<u>0%</u>
Total	<u>24</u>	<u>100%</u>

C. Medicare Supplement - Paid Claims:

A sample of one hundred (100) paid claims was selected using ACL software. The following was determined:

1. Seventeen (17) files or seventeen percent (17%) were deemed invalid records as they were claims administered by Advance PCS and did not represent actual paid Medicare Supplement claims.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann. § 38-13-120 (as amended), which provides,

“All companies doing any kind of insurance business in this State shall make and keep a full and correct record of the business done by them....” and
- b. NAIC Market Conduct Examiners Handbook – Claims - Standard 5 – Claim files are adequately documented.

The time study for Medicare Supplement paid claims from date received to the date paid provides the following data:

<u>Number of Days</u>	<u>Number of Claims</u>	<u>Percent of Total</u>
0 - 10	83	100%
11 - 20	0	0%
21 - 30	0	0%
31 - 60	<u>0</u>	<u>0%</u>
Total	<u>83</u>	<u>100%</u>

D. Individual - Denied Claims:

A sample of one hundred (100) individual denied claims was selected using ACL software.

1. Two (2) claims or two percent (2%) were deemed invalid records, as they represented paid claims; and
2. Ten (10) claims or ten percent (10%) took longer than thirty (30) days to deny from the date proof of loss was received.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann. § 38-59-20 (as amended), which provides,

“Any of the following acts by an insurer doing accident and health insurance, property insurance, casualty insurance, surety insurance, marine insurance, or title insurance business, if committed without just cause and performed with such frequency as to indicate a general business practice, constitutes improper claim practices.

 - (2) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, including third-party claims arising under liability insurance policies;”
- b. S.C. Code Ann. § 38-13-10 (A) (as amended) which provides,

“...the Director or his designee shall consider compliance with ... and other criteria set forth in the Examiners’ Handbook adopted by the National Association of Insurance Commissioners and in effect when the director or his designee exercises his authority under this subsection;” and
- c. NAIC Market Conduct Examiners Handbook - Claims - Standard 3 – Claims are settled in a timely manner as required by statutes, rules, and regulations.

The time study for individual denied claims from proof of loss completion date to date denied provides the following data:

<u>Number of Days</u>	<u>Number of Claims</u>	<u>Percent of Total</u>
0 - 10	88	90%
11 - 20	0	0%
21 - 30	0	0%
31 - 60	<u>10</u>	10%
Total	<u>98</u>	<u>100%</u>

E. Small Group - Denied Claims:

A sample of fifty (50) small group denied claims was selected using ACL software.

1. One (1) claim file or two percent (2%) was deemed an invalid record, as it represented a paid claim;
2. One (1) claim file or two percent (2%) was deemed an incomplete record in that part of the Explanation of Benefits (EOB) transaction representing the denied portion, could not be provided; and
3. Six (6) claims or thirteen percent (13%) took longer than thirty (30) days to deny from the date proof of loss was received.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann. § 38-59-20 (2) (as amended) which provides,

“Any of the following acts by an insurer doing accident and health insurance, property insurance, casualty insurance, surety insurance, marine insurance, or title insurance, if committed without just cause and performed with such frequency as to indicate a general business practice constitutes improper claims practices.

- (2) “Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies, including third-party claims arising under liability insurance policies.”

- b. S.C. Code Ann. § 38-13-10 (A) (as amended) which provides,

“the Director or his designee shall consider compliance with criteria set forth in the Examiners’ Handbook adopted by the National Association of

Insurance Commissioners and in effect when the director or his designee exercises his authority under this subsection.”

- c. NAIC Market Conduct Examiners Handbook - Claims - Standard 3 – Claims are settled in a timely manner as required by statutes, rules, and regulations.

The time study for small group denied claims from proof of loss completion date to date denied provides the following data:

<u>Number of Days</u>	<u>Number of Claims</u>	<u>Percent of Total</u>
0 – 10	23	48%
11 – 20	12	25%
21 – 30	7	14%
>30	<u>6</u>	<u>13%</u>
Total	<u>48</u>	<u>100%</u>

F. Large Group - Denied Claims:

A sample of one hundred (100) large group denied claims was selected using ACL software.

1. One (1) claim file or one percent (1%) was deemed an invalid record, as it represented a paid claim; and
2. One (1) claim file or one percent (1%) took longer than thirty (30) days to deny.

It is recommended the Insurer establish procedures to ensure proper identification of its claims history data and such information is consistent with market conduct examination requirements.

The time study for large group denied claims from proof of loss completion date to date denied provides the following data:

<u>Number of Days</u>	<u>Number of Claims</u>	<u>Percent of Total</u>
0 – 10	29	59%
11 – 20	13	27%
21 – 30	6	12%
> 30	<u>1</u>	<u>2%</u>
Total	<u>49</u>	<u>100%</u>

G. Medicare Supplement - Denied Claims:

A sample of one hundred (100) Medicare supplement denied claims was selected using ACL software.

1. Ten (10) claims or ten percent (10%) were deemed invalid records, as these files belonged to an affiliated company.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann. § 38-13-120 (as amended), which provides,

“All companies doing any kind of insurance business in this State shall make and keep a full and correct record of the business done by them...” and
- b. NAIC Market Conduct Examiners Handbook – Claims - Standard 5 – Claim files are adequately documented.

The time study for Medicare Supplement denied claims from date received to the date denied provides the following data:

<u>Number of Days</u>	<u>Number of Claims</u>	<u>Percent of Total</u>
0 – 10	48	53%
11 – 20	42	47%
21 – 30	0	0%
31 – 60	<u>0</u>	<u>0%</u>
Total	<u>90</u>	<u>100%</u>

H. Open Claims:

A sample of one hundred (100) open claims was selected using ACL software and was reviewed for justifiable reasons of being open and unpaid.

1. Seven (7) open claim files or seven percent (7%), were deemed incomplete records, as one (1) file was missing the remittance form, three (3) files were missing the EOB forms, and three (3) files did not provide the reasons why the claim had been denied or what had been paid.

It appears the Insurer is in non-compliance with the following:

- a. S.C. Code Ann. § 38-13-120 (as amended), which provides,

“All companies doing any kind of insurance business in this State shall make and keep a full and correct record of the business done by them...” and

- b. NAIC Market Conduct Examiners Handbook – Claims - Standard 5 – Claim files are adequately documented.

The following provides an analysis of the open claims that were paid prior to the on-site examination:

<u>Number of Days</u>	<u>Number of Claims</u>	<u>Percent of Total</u>
0 – 10	79	79%
11 – 20	<u>1</u>	<u>1%</u>
Total	<u>80</u>	<u>80%</u>

The following represents the open claims that were denied prior to the on-site examination:

<u>Number of Days</u>	<u>Number of Claims</u>	<u>Percent of Total</u>
0 - 10	<u>20</u>	<u>20%</u>
Total	<u>20</u>	<u>20%</u>

I. Litigated Claims:

All litigated claims’ files or one hundred percent (100%) of the closed litigated claims’ files during the examination period were reviewed. No litigated claims’ files that were open as of December 31, 2002 were included. The original listing of litigated claims provided by the Insurer included ASO cases. After a final review by the Insurer’s Legal Department, it was determined that the final number of thirty-eight (38) litigated claims’ files would be provided for review. The request to review litigated claims’ files was made to the Insurer on June 12, 2003. On August 11, 2003, the first group of files was provided to the examiners. The following were noted:

1. Eighteen (18) files or forty-seven percent (47%) represented legal actions taken by members or their legal representatives, who were insured under individual health plans;

2. Nineteen (19) files or fifty percent (50%) represented legal actions taken by members or their legal representatives, who were insured under employer group health plans; and
3. One (1) file or three percent (3%) represented legal actions by a provider/facility.

The Insurer settled thirty-two (32) or eighty four percent (84%) of the files reviewed. Six (6) or sixteen percent (16%) were dismissed. It is recommended the Insurer implement procedures to ensure claims are paid timely without the insured/provider having to seek legal representation to have such claims paid to comply with:

- a. S.C. Code Ann. 38-59-20 (as amended) which provides,

“Any of the following acts by an insurer doing accident and health insurance, property insurance, casualty insurance, surety insurance, marine insurance, or title insurance business, if committed without just cause and performed with such frequency as to indicate a general business practice, constitutes improper claims practices.

- (4) Not attempting in good faith to effect prompt, fair, and equitable settlement of claims, including third-party liability claims, submitted to it in which liability has become reasonably clear, and
- (5) Compelling policyholders or claimants, including third-party claimants under liability policies, to institute suits to recover amounts reasonably due or payable with respect to claims arising under its policies by offering substantially less than the amounts ultimately recovered through suits brought by claimants or through settlements with their attorneys employed as a result of the inability of the claimants to effect reasonable settlements with the insurers.”

- b. NAIC Market Conduct Examiners Handbook – Claims – Standard 11 – which provides, “Claim handling practices do not compel claimants to instigate litigation, in cases of clear liability and coverage, to recover amounts reasonably due under policies by offering substantially less than is due under the policy.”

An examination request was made to the Insurer, for an internal review to be made concerning litigated actions caused by agents misrepresenting the facts disclosed at the time of applications for insurance. Two (2) litigated cases reviewed were subject to this request. The Insurer was requested to respond to the Department within thirty (30) days, as to its procedures for

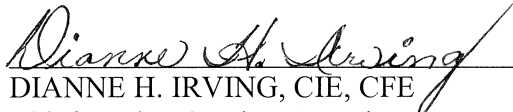
monitoring agents' new business, when possible misrepresentation of facts concerning preexisting health questions are raised by the consumer or by the Insurer using post claim underwriting procedures. The Insurer responded timely to this request indicating that procedures had been instigated to monitor agents' activities as a result of consumer complaints.

X. CONCLUSION

Customary examination procedures as set forth in the NAIC Market Conduct Examiners Handbook and guidelines of the Department have been followed in conducting the examination of the market conduct affairs of Blue Cross and Blue Shield of South Carolina as set forth in this Report on Examination.

In addition to the undersigned, C. Kenneth Johnson, AIE, FLMI, AIRC, Examiner-in-Charge; Twyla M. Kelly, Market Conduct Examiner; Elizabeth S. Slice, FLMI, CIE, Market Conduct Examiner; Rick Freeman, Market Conduct Examiner, and Yolanda Hudley, Market Conduct Examiner, participated in various phases of this examination.

Respectfully submitted,


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